

A WHOLISTIC MODEL OF CANCER CARE
FOR NURSING PRACTICE

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ABSTRACT

Nursing today is affected by challenges to the beliefs and values underlying the delivery of health care services. Through nursing theory development, nursing has embraced a new paradigm in which the scientific medical model is being replaced by a model based on the concept of wholism. **Key ideas** representing a wholistic paradigm of health appear with increasing frequency in the nursing literature, demonstrating the diffusion of a new and different perspective of the practice of nursing.

The purpose of this study was to develop a wholistic model of cancer care for nursing practice. The theoretical foundation for the model was derived largely from the nursing theory proposed by Margaret Newman, crisis theory and cancer nursing theory. Case studies from oncology nursing practice also were used in the development of the model.

The wholistic model of cancer care for nursing practice developed embraces the new emerging nursing paradigm that redefines health to include a broader definition that allows the person with cancer to enter the health care system in a new way, as an equal partner, and to convert the cancer experience into a positive growth process.

The wholistic model incorporates nursing's metaparadigm concepts of nursing, person, environment and health as well as the additional concepts of hope, wholism, movement, transformation and disorder. The focus is on the whole person that includes the cancer and views the patterns of interaction of the person and environment as the path to health.

A health within illness perspective has implications for advanced clinical nursing practice. This model adds to the advancement of nursing theory development and nursing philosophy by considering illness as an opportunity for awareness and growth. It also shifts the focus of health care from fighting the enemy of illness to learning about oneself through the illness experience. The model also has implications for nursing practice, education and administration.

CHAPTER ONE

THE PROBLEM

In 1990, over one million persons were newly diagnosed with cancer in the United States. It is predicted that cancer will surpass heart disease as the number one cause of death by the year 2000 (Greenwald & Sondik, 1986). Because cancer will affect so many people, the challenge to the nursing profession in the care of persons diagnosed with cancer will be far reaching. The person with cancer presents varied opportunities to nursing--from providing technical proficiency in the acute care setting to education and health promotion of the general public in the area of cancer risk and prevention.

A diagnosis of cancer can be devastating to persons and their families as they face a multitude of physical, emotional, spiritual and social stresses from the effects of treatment, changes in lifestyle, disruption of home and family roles, and fears of recurrence. People with cancer are challenged by changes in their endurance and strength, reproductive capacity, sexuality and body image, as well as their own mortality.

As the incidence and prevalence of cancer increase,

nursing will be challenged to find ways to care creatively for persons with cancer and their families. Incorporating care to encompass the whole person, not just a body part or system, will be essential for nursing practice.

The traditional medical model, in which the primary focus is on the diagnosis and treatment of symptoms and disease, has been the ruling paradigm for much of nursing's history. In recent years, however, through nursing theory development, a new paradigm has emerged. Nursing theory now is in a state of transition, with a theoretical shift away from a strongly empirical and logical orientation toward a more wholistic and humanistic approach (Silva & Rothbart, 1984).

One aspect of the evolving nursing paradigm is the conceptualization of illness as a health experience. Envisioning illness as a health experience is contrary to the predominant health and illness paradigm. Traditionally viewed as opposite of health, illness historically has been viewed as that which was to be eradicated. This conceptualization of illness as the enemy obscures viewing illness as a potentially positive health experience. The view of illness as an enemy is being challenged by quality of life issues and

increasing interest in personal transformation during illness (Jaffe, 1985; Pelletier, 1977; Siegel, 1986). A view is emerging in which illness is perceived as an opportunity to learn about oneself (Pelletier, 1977) and to reflect on the meaningfulness of life (Moos, 1982).

The view that encompasses health within illness is compatible with nursing goals and philosophy. It assists in achieving the basic goal of nursing which is to promote health and assist in the reparative process of illness (Nightingale, 1860).

Early nursing theory depicted health within illness (Peplau, 1952; Sarosi, 1968; Travelbee, 1971). In addition, such health themes are reflected in nursing's theory development in which health is viewed as expanding consciousness (Newman, 1979); transcending (Parse, 1981); developing human potential (Paterson & Zderad, 1976); the helicy principle (Rogers, 1970); discovery of being (Sarosi, 1968); and increasing harmony (Watson, 1985). The historical link of nursing to the growth and opportunity aspects of crisis theory (Aguilera & Messick, 1976; Narayan & Joslin, 1980) and developmental theory (Parse, 1981; Reed, 1983) also suggests a health within illness conceptualization.

Although a paradigm shift toward humanism and

wholism has emerged in nursing, few models have been developed that provide nurse clinicians with direction to actualize these notions in clinical nursing practice. Currently no models for cancer care exist in the nursing literature that incorporate wholism and the conceptualization of health within illness. It becomes evident that with the increasing incidence of cancer, there will be a growing need for the development of a model of cancer care for nursing practice that is consistent with the emerging nursing paradigm.

Purpose of the Study

The purpose of this study was to develop a wholistic model of cancer care for nursing practice that explicates the concept of health within illness consistent with nursing's emerging paradigm. This model was based on a synthesis of an extensive review of the current nursing theoretical literature and cancer nursing literature as well as from extensive clinical experience in oncology. Specific objectives included a redefinition of the term "health" and an application of this definition to the health within illness experience of the person with cancer.

Theoretical Basis of the Study

Margaret Newman's (1976; 1986) nursing model of

health as expanding consciousness and crisis theory provided the major theoretical bases for the development of the model. Newman (1979), expanding on a concept of health and illness suggested by Rogers (1970), proposed a view of health that includes a dialectical fusion of disease and non-disease, bringing about the synthesis of health. The tension in illness can allow patterns of expanding consciousness to emerge. Serving as an integrating factor, illness may facilitate desired change for the person or growth. Such change is reflected in the person-environment interactional pattern.

Crisis theory also supports the health within illness perspective. Learning about or coping with an illness is a potential crisis experience providing an opportunity for growth. The threat within the crisis situation poses a situation for a possible increase in a person's level of functioning. A crisis can facilitate personality growth (Caplan, 1964), increase mental health (Rapaport, 1962), and produce an increase in cognitive awareness (Golan, 1969; Hall, 1986).

Initial Review of the Literature

The literature related to the health within illness experience is available within the theoretical

formulations of Newman (1979, 1986); Moos (1982); Moss (1985); Pelletier (1977); and Siegel (1986). Research related to the health within illness experience is limited, however, and is most often reflected within case studies (Medora & Chessser, 1981; Rawnsley, 1982) and personal accounts.

In addition, literature in the area of transpersonal psychology was reviewed for its relevance to the development of the wholistic model for cancer nursing. Some case studies relating to the health within illness concept were analyzed for relevance to the model. The literature review also examined additional cancer literature.

Methodology

The purpose of this study was to develop a wholistic model of cancer care for nursing practice that explicates the emerging paradigm of the health within illness concept. This was a qualitative study consisting of philosophical research. It was foundational in nature, attempting to redefine concepts and constructs in the process of developing a wholistic model of cancer care for nursing practice.

The methodology incorporated aspects of existential phenomenology (Oiler, 1982; Valle & King,

1978; Watson, 1985) and Margaret Newman's (1990) emerging theory of health as expanded consciousness. The study was based on methodological assumptions that emphasize the whole, rather than the parts, and process rather than structure.

The development of the model was based on foundational theoretical knowledge from an extensive literature review as well as from the development of a personal philosophy for oncology nursing practice. This conceptual model of wholistic cancer care was formulated by personal views of and assumptions about the world and nursing. The formulation of the model was a more intellectual than empirical endeavor, although empirical observations influenced the model's development.

The content of the model was presented in the form of abstract and general concepts and propositions. The ideas and statements reflected a distinctive perspective of the four metaparadigm concepts of nursing--person, environment, health, and nursing--as well as other relevant concepts.

To direct the development and analysis of the wholistic model for cancer nursing care, a framework of analysis of nursing model development proposed by

Fawcett (1989) was employed. The framework consists of a series of questions to consider about the development, primary focus, content and areas of concern of the model. The questions allowed for an ongoing examination of the overall structure, as well as the content of the model, which permitted a view of the model's gestalt or wholeness. The following questions comprise the framework (Fawcett, 1989, p. 43): What is the historical evolution of the conceptual model? What approach to the development of nursing knowledge does the model exemplify? Upon what philosophical assumptions is the model based? How are nursing's four metaparadigm concepts--person, health, environment, and nursing--explicated in the model? What statements are made about the relationships among the four metaparadigm concepts? What areas of concern are identified by the conceptual model?

Organizational Structure of the Study

The study is organized into four chapters. Chapter One introduces the problem to be investigated, delineates the purpose of the study, and presents the methodology, structure and the significance of the study for nursing. Chapter Two presents a review of the nursing and cancer literature and provides the

theoretical and empirical foundation for the study. Chapter Three presents a detailed description of the model. Chapter Four provides an analysis and discussion of the model developed and addresses the implications of the model for nursing.

Significance to Nursing

As the most plentiful and accessible health care discipline, nursing has a mandate from society to use its body of knowledge to promote and preserve the health of humankind. Philosophy is concerned with the pursuit of knowledge in its broadest sense. It attempts to provide a unified view of phenomena and find coherence and continuity in the whole realm of thought and experiences. It provides the foundation that queries the worth of phenomena that can lead to greater understanding and the formulation of priorities and goals.

Philosophical research allows nurses to examine and comprehend nursing in its entirety. It enables nurses to reconsider the fundamental assumptions, concepts, generalizations, values and purposes of nursing practice.

With the recent paradigm shift in nursing, there is an urgent need to develop nursing practice models that

are consistent with a world view that characterizes nursing as a human rather than a medical science and emphasizes wholism, humanism, multiple realities, process, openness, harmony, and consciousness. The incongruity of nursing practice models with the evolving humanistic philosophy of nursing damages nursing's capacity to be socially responsible, develop compassionate and scholarly nurse clinicians needed to care for cancer clients, and lead nursing into the new millenium.

Summary

This chapter discussed the problem and reasons for the development of a wholistic model of cancer care for nursing practice. The theoretical basis for the study, methodology, and the relevant literature used for model development were introduced. The significance of this study to nursing concluded the chapter.

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this study was to develop a wholistic model of cancer care for nursing practice that explicates the concept of health within illness and is consistent with nursing's new emerging paradigm. Chapter Two presents the theoretical and empirical foundation for the study and focuses on the review of the literature in the areas of nursing theory development, crisis theory and cancer care.

Theoretical Foundation

The theoretical foundation used for development of the wholistic model of cancer care is based largely on crisis and nursing theory. Each theory will be reviewed for relevance to model development. As a professional discipline committed to understanding and treating the whole person, nursing has a responsibility to examine data generated from clinical situations to clarify the issues and conflicts that surface when persons struggle with the diagnosis of cancer.

It is apparent that cancer represents a crisis. Cancer does not in itself create a set of emotional responses peculiar to the disease. Instead, as an intense pervasive stressor, it summons the customary

coping mechanisms used by the person when faced with a threatening event. It exaggerates the conflicts and inadequacies that existed premorbidly (Weisman, 1979). In discussing his crisis theory, Caplan (1981) described responses to stressful events in four interrelated phases. Phase I behaviors are aimed at eliminating the stress by direct action or escape. Phase II behaviors involve the acquisition of new learning to achieve mastery over the stressor and its consequences. Phase III and IV behaviors involve the intrapsychic processes of defense and internal readjustment that are necessary components for resolution. The importance of a support system is emphasized.

The diagnosis of a malignancy is a serious challenge to the integrity of the living system or person. Cancer constitutes a focal experience of existential anxiety. It is unmitigated separation anxiety precipitated by actual and anticipated losses. Cancer constitutes a crisis in that the usual problem-solving methods are ineffective in controlling anxiety. Moreover, the totality and intensity of the threat dramatically evoke what Maan has called the "basic universal conflict situation" (Maan, 1973). According

to Maan, conflicts of dependency, passivity, diminished self-esteem and unresolved or delayed grief "express all the ways that humans experience loss" (Maan, 1973, p. 27).

The moral choices, emotional adjustments, and life transitions associated with pregnancy, death, illness, or separation (from loved ones or loved jobs) are emotionally intense situations that often stimulate spiritual experiences. During emotionally stressful situations, the power to create and destroy life and the power to pull oneself toward or away from loving relationships and creative expression are more evident. One is forced to acknowledge his/her vulnerability.

Bragdon (1988) conceptualized spiritual emergency as a process of personal awakening that moves one into a level of perceiving and functioning that is beyond normal ego functioning. Spiritual emergency processes are part of the passage of human development into transpersonal realms. Wilber (1980) explored these processes in his theory of the spectrum of consciousness that illustrates the movement from prepersonal to transpersonal consciousness through the life cycle.

Thomas, a social theorist, viewed crisis as a

catalyst that disturbs old habits, evokes new responses, and becomes a major factor in charting new developments (Volkhart, 1951). Thus conceived, a crisis is a call to a new action. The challenge it provokes may bring forth new coping mechanisms that serve to strengthen the individual's adaptive capacity and thereby, in general, to raise his/her level of mental health.

A state of crisis is not an illness. Tyhurst, a Canadian social psychiatrist, conceptualized that illness is an opportunity for growth regardless of how severe the impasse may appear (Tyhurst, 1957). The ego tends to respond to a threat with a need for integrity while manifesting anxiety. Loss or deprivation is met with depression. If the problem is viewed as a challenge, it is more likely to be met with a mobilization of energy and purposive problem-solving activities.

Medora and Chesser (1981) proposed that a crisis situation is a time of potential growth or stunting of growth. A crisis situation is often characterized by severe depression, a feeling of helplessness, extreme anxiety, hate and a sense of isolation. With appropriate support, however, a crisis can propel one

toward personal growth and enhancement.

In addition to crisis theory, nursing theory was reviewed for relevance to the development of a wholistic model of cancer care for nursing practice. In recent years, nursing has become disenchanted with traditional approaches to health and illness care. This disenchantment has led to a reexamination of the concept of health and the role of the nurse in providing wholistic care to clients to promote health. Increasingly, nursing has begun to align itself with the concepts of health and wellness in contrast to medicine's traditional alignment with illness and disease states (Narayan and Joslin, 1980).

Early nursing theory depicted health within illness with works by Peplau (1952), Sarosi (1968), and Travelbee (1971). The historical link of nursing to the growth and opportunity aspects of crisis theory (Aguilera & Messick, 1974; Fitzpatrick, 1982; Narayan and Joslin, 1980; Sarosi, 1968) and developmental theory (Fitzpatrick, 1983; Parse, 1981; Reed, 1983; Stevenson, 1977; 1983) also suggested a health within illness conceptualization.

These authors posed alternative concepts of health that have two major commonalities. The first

commonality is that health is more than the absence of disease or symptoms. It implies that unity of all aspects of the individual--mind, body, and spirit. No one aspect can be separated from the others. Such a view of health incorporates the genetic make-up of the individual, developmental patterns, the interaction of person and environment and processes such as learning and self-actualization.

A second commonality is that humans are open systems and subsystems of other systems such as the family and community. Within this open system, the individual continually strives toward greater order, complexity and self-differentiation. From this one can infer that humans are capable of learning, acquiring knowledge, building cognitive maps or schema and designing and choosing strategies for coping with life events.

When analyzing this concept of health in terms of the cancer experience, it provides a new way of envisioning the illness as a health experience. Much of what has been written in the literature has utilized the medical model. The paradigm of illness as the enemy obscures viewing illness as a potentially positive health experience. Kuhn (1990) believed that

a new paradigm takes hold only when the ruling paradigm is no longer sufficient to solve the problems and meet the needs of a social system. There is, however, a clear shift toward moving away from the medical model, developing a wholistic perspective when caring for someone with cancer, and allowing for the envisioning of health within illness the potential for growth and expanded consciousness.

Maslow (1970) defined growth as the various processes that propel the person toward ultimate self-actualization. He contended that persons become fully whole only when their innermost nature is nurtured and developed to its fullest extent. Healthy people are those who have sufficiently gratified their basic needs for safety, love and self-esteem so they are motivated to self-actualize.

When emotional stress is most intense, there is a turning point when a person reorients life toward continued growth, retrenches in the same patterns and self-structure, or regresses. The inspiration to open to continued growth most frequently comes from a personal epiphany, a spiritual experience, or a deep sharing with another person--a deepening of love, of trust and openness to life. This is most apt to happen

when a helper, therapist, nurse, teacher or compassionate friend is present (Bragdon, 1988).

Without the deep connection to a supportive source, personal or transpersonal, one who is in intense emotional distress typically feels isolated and overwhelmed. One may regress to lower levels of functioning or rigidify one's identification with one's current level of development.

Nursing theorist Margaret Newman (1979) postulated that health encompasses conditions heretofore described as illness, or in medical terms, pathology. These "pathological" conditions can be considered a manifestation of the total pattern of the individual, and it is possible for a person to move toward expanded consciousness or higher levels of awareness in the face of illness. Health, therefore, can exist within the confines of illness. Newman's theory was derived primarily from Bentov's (1977) ideas that depicted the spectrum of life as a process of evolving toward higher levels of consciousness. Bentov (1977) defined consciousness as "the capacity of a system to respond to stimuli" (p. 58). With this premise, cancer can be viewed as part of a movement toward increasing complexity and the organization of the individual, evidenced by potential for growth and higher levels of

consciousness or health (Newman, 1981).

Newman's theory of health as expanding consciousness stems from Rogers's theory of unitary human beings (Rogers, 1970). Rogers's assumptions regarding the patterning of persons in interaction with the environment are basic to Newman's view that consciousness is a manifestation of an evolving pattern of person-environment interaction. Newman's definition of consciousness is important for an understanding of her theory. The concept of consciousness is defined as the informational capacity of the system (in this case, the human being); that is, the ability of the system to interact with the environment. Consciousness includes not only the cognitive and affective awareness that is normally associated with consciousness, but also the interconnectedness of the entire living system that includes physiochemical maintenance and growth processes as well as the immune system.

Rogers's insistence that health and illness are simply manifestations of the rhythmic fluctuations of the life process led Newman to view health and illness as a unitary process moving through variations of order-disorder (Newman, 1986). From this standpoint, one can no longer think of health and illness in the

dichotomous way characterized by the medical paradigm; that is, health as absence of disease or health as a continuum from wellness to illness. **Health and the** evolving pattern of consciousness are the same.

The current paradigm shift in nursing practice to a more wholistic approach is supported in the literature by Johnson (1989) who studied nursing literature over a thirty-year period and identified four main characteristics that are central to this convergence. First, the wholistic paradigm of health within nursing appears to have taken the form of a philosophy or an approach to the care of others that facilitates the integration, harmony and balance of body, mind and spirit. No matter what skills or tasks are performed by the nurse, the salient dimension is the underlying beliefs and values that are brought to bear on how skills are used and tasks accomplished. Self-awareness, centeredness, and caring suggest an internal set of principles underlying this philosophy.

Second, the focus in the mind of the nurse is on wholeness. The client is not seen as having a disease to be cured but rather as a whole person in the process of self-healing. Spirituality, consciousness, self-concept, lifestyle and well-being are important

dimensions of the person that need to be considered within the practice of nursing.

Third, the experience of illness is viewed as an opportunity for growth and expanded consciousness. This experience promotes awareness of the interrelationship of attitudes, values, beliefs, perception, lifestyles and health. Illness invites persons to pause and reflect on the important dimensions of their lives and to make changes that encourage a more balanced and integrated state of being.

Fourth, the relationship between the client and nurse is a reciprocal one in which each benefits from the interaction and each grows in self-awareness. The energy fields of both persons are interconnected. The energy fields or the interconnectedness empower both individuals and enhance health. Spiritual emergence is recognized as a valid component of health and results in positive changes among the client population. Spiritual emergence transcends religious preference and is more appropriately defined as a unifying force that integrates the life process in such a way that meaning in life and commitment to others are ultimate concerns (Richardson & Noland, 1984).

From the crisis and nursing literature, there are several components of wholistic health that can be summarized. First, health is more than the absence of disease or symptoms. It implies the unity of all aspects of the individual: mind, body and spirit. No one aspect can be separated from the others. Such a view of health incorporates the genetic makeup of the individual, developmental patterns, the interaction of person and the environment and processes such as learning and self-actualization.

Second, humans are open systems and subsystems of other systems. Healthy individuals have a clear sense of "who I am" and "where am I going" and an organizing sense of self and life purpose.

A third aspect is that one's attitudes, values, perceptions and beliefs affect one's health and can lead to alterations in one's health status. Fourth, maximum health requires the allocation of various resources or supplies from within and outside the individual. These comprise matter, energy and information (Hart and Harriott, 1977).

A fifth aspect of wholistic health is that the focus of health and healing exists within the individual. The nurse can act as a catalyst or facilitator for healing, but change in the health state

can come only from within the individual.

The final notion is that states of health that are not maximal can be opportunities for growth and learning if adequately utilized by the individual. In keeping with this view, the symptoms are not the focus; rather, the interruption in balance among the mind-body-spirit aspects is the focus (Narayan and Joslin, 1980).

Review of Cancer Research

In a study done by Moch (1990), 20 women diagnosed with breast cancer aged 38-60 were questioned in an attempt to have them describe their experiences with breast cancer through two open-ended interviews. Through thematic analysis and patterning of the person-environment analyses based on the North American Diagnosis Association Taxonomy I dimensions (1987), themes consistent with health as expanding consciousness emerged. The women in the study provided evidence of their own growth and development through the illness experience with descriptive accounts of their experiences and identified changes in person-environment interactions. Sixty percent of the respondents described changes in perceiving the cancer experiences as indicative of increasing openness to the environment. Specific descriptions of perceptual

changes included a wish to be awake longer, increased attention to dreams, increased sensitivity to others and taking more time to experience nature and other people.

Rawnsley (1982) has conducted extensive psychotherapy with people with recurrent cancer and deduced that the most narrow bounds of health are set by the clinical model, which requires complete absence of the signs and symptoms of disease or malfunction. Clearly this standard is inadequate as the only measure of health in persons with cancer or, for that matter, for anyone with a chronic disease, because it does not address other dimensions of the human potential. Rawnsley proposed a wholistic practice model in psychotherapy and presented a case study as a clinical illustration from her psychotherapy practice of people with recurrent cancer.

Kennedy, Tellegen, Kennedy, and Havernich (1976) studied 22 people with advanced cancer (breast, endometrium, testis and lymphoma) who had undergone complete remission that had been maintained for 5-20 years since the last therapy. They reported that the subjects overall had attitudes that were very positive toward life and the future ($p = .054$) and a greater

appreciation of time, life, people and interpersonal relations ($p = .002$). The subjects were less concerned about the nonessentials of life. The researchers concluded that recovery from advanced cancer led the subjects to growth, expanded consciousness, and ultimately health. No cancer control group was studied in this research.

Taylor (1983) interviewed 78 women with breast cancer and over half of the subjects reported a life reappraisal due to the cancer experience. Some of the women described a new attitude toward life, an increase in self-knowledge, and a re-ordering of priorities with an emphasis on relationships. The subjects also reported increased consciousness in their middle and later years.

Ryff and Dunn (1985) examined the relationship between stressful life events and personality development in a sample of middle and old-aged adults (115 females, 53 males). The general hypothesis was that crises may contribute to personal growth. Life stresses were assessed with the Life Experiences Survey, and personality development was measured with four structured scales operationalized from developmental theories. Together these scales dealt

with viewing oneself as effective in guiding and influencing others as well as having a sense of integration and meaningfulness about one's life. The findings revealed weak to moderate correlations between life stress ratings and personal development scores.

Harrell (1972) in an article entitled, "To Lose A Breast", revealed from a personal experience with her own breast cancer encounter that her insights increased her empathy and led her to new awareness and growth. She also stated that one had two directions to go: one could allow the cancer to dominate and overwhelm or one could choose to grow and learn about oneself through this opportunity.

Pelletier (1977) summarized the findings of twenty studies of people who experienced spontaneous remission from cancer and concluded that these survivors experienced the following psychological transformations:

- (1) A profound change in inner being, in their sense of who they are and what life is all about for them. Many experienced spiritual rebirth and dedicated themselves to new life tasks.

- (2) Profound changes in personal relationships, including a sense that people closest to them were now

connected in a deeper, more solid, and more open and expressive way.

(3) Profound changes in their relationship to their bodies, including greater sensitivity to internal feelings, body rhythms, and intuitions.

(4) Seeing their recovery not as a gift or a miracle, but as a struggle they had won, something their behavior, inner resources and personal change process had helped to bring about.

Jaffe (1985) conducted studies on people experiencing all kinds of crisis from illness to disasters and concluded that a crisis can lead to self-renewal which in turn leads to healing. This self-renewal process includes the person playing an active role as well as using the presence of strong support systems. The people who experienced this self-renewal did not perish or succumb to depression, passivity or self-pity. In this regard, his crisis theory supports the health within illness perspective in that learning about or coping with an illness episode is a crisis experience providing an opportunity for growth.

Case Studies

Through clinical practice in oncology nursing with people experiencing various stages of cancer, it has

become evident that the health within illness perspective emerges often spontaneously but more frequently with support and care with the nurse as a catalyst for health.

The following two case studies are from personal practice in oncology nursing. These people were met during their referral to a private practice radiation oncologist as they sought treatment for their cancers. They also attended and participated in a support group for people and their families who have cancer that was facilitated by the researcher.

Becky, 39, was a mother of three young children and the major financial contributor as well as the "glue" that held the family together. She was diagnosed with lung cancer that had spread to her brain and subcutaneous tissue. Not only could she no longer work, drive or do the same tasks with her children, but she was also facing her imminent death. In the last few weeks of her life she was able, with support, to face her death with great resolve and dignity, continue to live and dream her dreams, and also provide real hope and encouragement to others experiencing a cancer diagnosis. She made the following comment close to her death: "I may be dying of cancer, but I feel healthier

than I've ever felt..."

Mary was a 66 year old woman, recently widowed, who three years ago had a mastectomy for breast cancer. She experienced a stroke in the recovery room following surgery and was paralyzed on the right side and could not talk. She went through two years of rehabilitation for the stroke and took six months of chemotherapy. She now walks and talks without assistance, is active in a support group for people with cancer, and is an inspiration to everyone who knows her. Mary continues to experience life to the fullest. She seeks out new challenges for herself and her comment was: "Even in the midst of all that happened, I kept learning and growing and I keep trying to do things I think I sometimes can't."

Summary

This chapter discussed the theoretical foundation for the wholistic model of cancer care for nursing practice. Crisis theory and nursing theory were examined, especially the concepts and theory developed by Margaret Newman, a contemporary nursing theorist. The cancer nursing literature also was reviewed and helped to establish and support the problem as stated in Chapter One. Case studies from personal oncology

nursing practice also were presented in support of the need for a wholistic model of cancer care.

CHAPTER THREE

THE WHOLISTIC MODEL OF CANCER CARE

A model or scientific paradigm, according to Kuhn (1970), is a set of interrelated assumptions about classes of phenomena. Models have a heuristic value in that they have a closely linked protocol or set of procedures for observing and analyzing phenomena. For a discipline like nursing, models can be useful because they combine theoretical assumptions, research-based knowledge, diagnostic problem-solving, and clinical intervention. A model is a link between concept and action and can function as a tool to coordinate the structure and process of a research study designed to improve the effectiveness and therapeutic value of nursing practice.

Given that a model of nursing is underpinned by a set of explicit and implicit assumptions based on the values and beliefs of their authors, there are two logical ways to consider the development of a model for nursing practice. These ways include matching the beliefs and values of the practitioners to those of the various models that exist and choose the closest fit, or constructing a tailor-made model of nursing from the practitioner's own values and beliefs that reflects the

practice situation. The latter was applicable to the development of the wholistic model of cancer nursing care.

Philosophy of the Model

Central to this wholistic model of cancer care is the development of a philosophy for practice. A philosophy for practice is defined as a "result of an exploration and agreement of minds about what nursing is in relation to the realities of shared practice" (Johns, 1989, p. 137). The value of philosophy is that nurses who share a common practice belief about nursing, within the context of their clinical practice, are more likely to give consistent and congruent care for the benefit of the client or person with cancer.

Constructing a model for practice from philosophy requires a systematic approach, conforming to certain criteria to ensure its validity. It is important to emphasize that the nature of the philosophy is about practice. In this respect, the philosophy becomes functional.

The wholistic model of cancer care is based on the belief that health and the evolving pattern of consciousness or expanding options are one and the same and are a process. Health exists within the confines of illness. It is a basic premise that a person with

cancer is struggling to become an individual, that is recognizing the being. This concept of being must be preserved and enhanced, allowed to flourish throughout the process of diagnosis, treatment and continued care. Person is a determinant of behavior and feelings and when unenhanced, results in negative feelings such as guilt, loss, anxiety, powerlessness and alienation, a form of regression or disorder. Disorder involves a perceived narrowing of options, diminished reliance on intuition and a fixed or generalized response to diverse experience. A person's behavioral repertoire becomes restricted so that communication and sensory reception can be distorted.

The human phenomenon of being is an abstract human component which, when allowed to flourish, leads one to consciousness or expanded options or growth. Consciousness or expanded options of the person include not only the cognitive and affective awareness that are normally associated with consciousness, but also the interconnectedness of the entire living system. Consciousness or expanded options is not an end process, the journey accomplished. There are always finer, more integrated levels of awareness. As one moves to consciousness or expanded options, there is

this successive refinement of the person that becomes more substantial, more a reflection of life's intrinsic wholeness. There is a quality of authenticity.

As the energy of the being heightens, the significance of the individual expands. There is a sense of collectivity. Consciousness or health is not an end in itself. It is a continuously expanding relatedness and responsibility to life as a whole.

The enhancement and growth of each person can emerge from a combination of events and nursing interventions: (1) viewing the individual from a wholistic perspective that recognizes the uniqueness of his/her personal experience; and (2) centering care of individuals around their uniqueness, recognizing their potential for growth in crisis and not simply compensating for physical illness. It involves recognition of patterns of individuals. Nursing action is intentional and not unwitting, and has as its goal assisting the individual with cancer to a heightened energy of consciousness or expanded options. The cancer is a part of the person, not necessarily something that has to be eradicated.

Concepts of the Model

Health

A view of health as the evolving pattern of the whole requires a nonfragmentary world view. This unified concept of health includes disease as a meaningful manifestation of the underlying pattern and precludes a dichotomous view of health and disease. This perspective represents a paradigm shift. It requires letting go of the old, manipulative view of health in which one can promote health by adopting certain behaviors and cure disease by submitting to prescribed treatments. This concept of health does not negate knowledge of disease and its treatment; it places such knowledge within the context of the whole rather than as the central focus.

Health is a process. It is the "flow of life" perceived as a kaleidoscopic evolution of patterning with paradoxes, contradictions, and ambiguities continually being synthesized into insights that lead to an everexpanding consciousness (Newman, 1983). Disease and non-disease are each reflections of a larger whole. Disease, if it is present, is not a separate entity; it is a manifestation of the person or being. Eliminating disease (the directive of the

medical model) does not necessarily enhance the individual. Actions toward this end may even impede the process of health. What is needed is recognition of the potential for health within illness and its action potential. Recognizing this potential is the key to the process of evolving to higher levels of consciousness or becoming healthy (Newman, 1986). Consciousness is not an aesthetic "higher activity" but is "simple existence." It involves empirical, cognitive, intuitive and spiritual knowing. When this occurs, it illuminates the possibilities for action. It is like the difference between being in the dark and turning on the light. When the light comes on, one can see the possibilities for movement.

In this model, it does not matter where one is in the process. There is no basis for rejecting any experience as irrelevant. The movement from now to expanded options (health) and beyond is like a sphere in which the radius grows larger with a consciousness embracing an everexpanding reality. This expansion is growth and development of new insights, not a rejection of the old, because what already exists acquires greater significance and meaning. There is connectedness to life in ways that could never have

been imagined before. The important factor is to get in touch with one's own pattern of interaction and recognize that whatever it is, the process is in progress and this experience leads one to expanding options or consciousness, ultimately health.

An example of this wholistic health is when an individual experiences a crisis such as the diagnosis of cancer, and instead of focusing on the symptomatology of the disease, the individual expands options to include the awareness of potential for growth. Health then becomes a process of opening. Reality for the individual expands, allowing for new connectedness to life beyond what has been imagined before. This shift or movement can be gradual or abrupt. If it is gradual, one may not realize it is happening immediately. If it is abrupt, it can become the most significant event of one's life. Sometimes it is difficult to envision the process of expanding options in the present moment, but recognition of the action potential of the process will open the way for health to occur. Even though the process appears at times to be disorganized or blocked, the direction of its unfolding is movement toward increased consciousness or health.

Health is viewed as the undivided wholeness of the person in interaction with the environment. Nursing practice is therefore directed toward recognizing the pattern of that interaction and accepting it as a process of evolving consciousness. The cancer is regarded as a manifestation of that pattern, not an entity external to it.

As a nurse providing care and information to the person with cancer, it is vital to be able to transcend disease as the entity to eradicate and to embrace it as a part of the person. This allows nurses to not only impart skills and information, but also expand the nurses' role and have as an objective an authentic involvement of themselves with the patient in a mutual relationship of pattern recognition and augmentation. Impetus for this kind of involvement includes not only caring for someone with cancer but also situations of childbirth and parenting or trying to cope with one's own health concerns.

This process involves being fully present with the patient in the immediate moment, moving into the patient's field and facilitating the insight of pattern recognition. This is non-limiting and goes beyond the roles of "nurse" and "patient." The nurse and patient are participants in a greater whole. They are not

separate persons. They are persons experiencing the pattern of consciousness formed by their interaction. Their relationship is based not only on problems and solutions, but a manifestation of the evolving consciousness of the whole. There is interconnectedness between nurse and patient and the environment.

Person/Being

There are two worlds in which one lives. For the most part, there is person, a tangible entity that is differentiated from an "everyday" physical world. In times of crises and in moments of awe, however, vulnerability and growth may provoke a sense of life as wholistic, as inseparable from an "eternal" world. While this world may be more intangible, it also can seem more real, as if one's actions during these moments are more authentic and somehow more personally meaningful than everyday actions that meet social expectations.

If asked to describe oneself, one typically offers tangible identity of vocation, residence and kinship. If pressed further, the response is "personalized" or streamlined from this social identity of expectations to a psychological identity that is outwardly

characterized by preferences, interests and habits. This psychological identity summarizes in a "personality" a set of traits that distinguish oneself from others.

General human development and rehabilitation of dysfunctional development seeks to strengthen this psychological dimension of self to develop fluency in both interpersonal skills and control of impulses. Self-identity becomes synonymous with personality and "personhood." Psychological health has been associated with an unencumbered personality or movement toward individuation. Increasingly, attention to optimal health has suggested the necessity of more than personhood as a measure of psychological health (Kabat-Zinn, 1990).

With the diagnosis of cancer, a lifetime devoted to strengthening personality to meet needs can suddenly seem inadequate. Confusion may transform a person to awareness of a dimension of self that has been overlooked but that may offer resources. Especially in crisis, an individual may intuit a dimension of life that has never really been touched, a dimension for which there has never been enough time, and that now takes on meaningfulness.

Every person experiences periods of life when it is apparent that there is no control. It may be a physical illness, the loss of a significant other or an overwhelming rapture such as the birth of a baby. Attempts to address this lack of control may feel more like compensation for loss than growth or health.

Within a disrupting sense of loss of a positive sense of wonder, there can be a sense of subtlety that opens one to life. Change occurs and where there may be a sense of defensiveness, there may also be a sense of opening and casting off extraneous attachments and, paradoxically, of becoming somehow "more." As one answers the question of the meaning of life, the answer comes from a larger dimension of self than personality.

In the face of crisis, a person can opt to continue a lifestyle that is strongly self-integrated, but access to resources can diminish and then a person will likely experience loss as a natural expectation of life. To cope with loss, personality validates adjustment, rehabilitation, redemption, reconstruction, recovery and survival to eliminate deficits. On the other hand, an individual who perceives self as somehow more-than-personality and integrates with experience finds crisis to be opportunity-based and expansive and not loss at all. Health within illness is a phenomenon

beyond person in which expanding and optimizing experiences are validated. Meaningfulness can be discovered in activity that, heretofore, seemed only a backdrop, and it can be life turning. Health is revisioned to a posture of control and encourages and validates attention to "being needs" rather than "deficiency needs."

A personal crisis such as a diagnosis of cancer can generate a richness of thought and emotion which overwhelms desires that, just moments before, seemed so very important. Personality can suddenly seem inadequate to address these moments, as if it is selfish or blind to the essence of life.

Maslow (1970) posited a psychology of being that validated being--experiences that heretofore appeared to most observers to be beyond ego--as aspects of self, as personal. Maslow observed that the development of a strong personality and general success in social relations did not assure for a sense of satisfying completeness. He and others eventually, though, viewed "being" as a dimension of all phases of human development.

While "person" describes an explicit entity, "being" is more descriptive of a process. Personality delineates a self-image and tends to serve this image.

Being is oriented toward presence in experience rather than serving an image. Being is a descriptor for the personal dimension of one's satisfying completeness. Being offers a sense of "we-ness" (inclusiveness) to offset the narrowness of "I-ness" or "me-ness" (exclusiveness). When conscious of being or when it is active, being is non-analytical (not searching for a purpose for existence).

Attention to being allows an individual to express self and is not concerned with knowing self. Active attention to being may not derive purpose or explicit meaning but does offer meaningfulness.

Being is not a better place than person for the nurse to intervene, but neither is it a secondary dimension or an adjunct to be addressed after more basic needs are met. Growth or healing can be evoked without explicit attention to being. An outcome that is judged positive by both the nurse and person seeking growth and healing, however, may involve implicit attention to elements of being. Table I summarizes the elements of person and being as conceptualized in the model for cancer care.

For life to be authentic and fulfilling, being must be expressed in personhood so that the two are not incompatible, and "self" is realized. For example, a

person's aspirations may be expressed explicitly in one's love of and feeling of "fit" with a vocation. Overall, a sense of incompatibility between the intangible and tangible, between structure and process and the everyday and the eternal should decline.

The great wisdom and its rewarding grace is to be two-in-one, differentiation with wholeness, that is to be down to earth, present and grounded, and to evoke an authenticity in personal actions that express a sense of expansiveness beyond personhood.

Table 1

Elements of Person and Being

Person (Exclusive)	Being (Inclusive)
Structure	Process
Explicit	Implicit
I-ness, me-ness	We-ness
Defined	Open
Temporal	Eternal
Anticipatory	Presence
Purpose/Meaning	Meaningfulness

Environment

Environment is not viewed as separate from person. It may be analogous to describe it as a larger autobiography of a person. Person evolves from the

environment and expresses the environment more than just interacting with it. The new focus is on the relatedness between person and environment. Laing (1967) developed the concept interexperience as the process of person needing to express environment. As persons see the connectedness and relatedness with environment, the person sees his/her wholeness. As wholeness is perceived, options open.

Movement is a natural condition of life and through this movement, person interacts with the environment. It is the patterns of interaction of person-environment that constitute health.

Environment itself is not viewed explicitly as a world of separate objects and events, but rather implicitly as a continuation of person. When environment is viewed in this way, cancer can be viewed not as an enemy but as an opportunity.

The person with cancer can be viewed not as a victim who has little to say about the situation, but as a person experiencing a new process that can lead one to expanded options. The cancer is not seen as a separate entity but as a manifestation of the pattern of person-environment interaction. Disease or cancer, then, can be regarded as a clue to pattern and can

assist people in becoming aware of their patterns of interacting with the environment.

Nursing

There are instances in which health, taken in its narrowest meaning as freedom from disease, is not an attainable goal, as evidenced, for example, in labels given to people such as terminal, hopeless, and chronic. Yet in actual practice, these humans' conditions call forth some of the most complete, expert, total, beautiful nursing care.

Nursing then, as a human response, implies the valuing of some human potential beyond the narrow concept of health taken as absence of disease. Nursing's concern is not merely with a person's well being, but with this more-being, with helping the individual become more as humanly possible in the particular life situation.

Capra (1982) pointed out that nursing is perhaps the best discipline prepared to offer health care within the new paradigm of health--health based on pattern recognition and facilitation rather than on diagnosis and treatment of disease. Nurses should be at the forefront, or perhaps at the interface, of health care offerings.

Currently nursing is functioning in both the old and the new paradigms. The old paradigm is based on the concept of health as the absence of disease. This is predominantly the medical model. Activity is directed toward identifying the disease and its cause and eliminating the disease via surgical or medical means. The disease is regarded as an entity in and of itself and as the enemy to be defeated. Nursing as a discipline in this model requires functional technicians for the purpose of implementing the medical regimen, observing and communicating the patient's condition, and providing assistance to the patient and family with activities of daily living.

The new paradigm, and the one supporting the model in this thesis, is based on health, with the individual wholeness of the person in interaction with the environment. Nursing practice is directed toward recognizing the pattern of that interaction and accepting it as a process of evolving consciousness. Disease is regarded as a manifestation of that pattern, not an entity external to it. Understanding this underlying pattern will facilitate change to higher levels of consciousness. Nurses functioning in this model have as their objective an authentic involvement of themselves with the patient in a mutual

relationship.

In a situation in which the old paradigm prevails, the nurse occupies a central, pivotal position between the patient and the larger health care system. It is a short-term responsibility involving performance of tasks related to the immediate medical regimen and self-care.

In the situation in which the new paradigm prevails, the nurse and the patient, as participants in the greater whole, are not nurse and patient. They are not separate persons. They are persons experiencing the pattern of consciousness formed by their interactions. Their relationship is based not only on the problems and solutions (old paradigm) but is a manifestation of the evolving consciousness of the whole (new paradigm).

Wholeness

Bohm (1983) has noted that persons viewed as individuals are viewed as universal:

The individual is universal and the universal is the individual. The word "individual" means undivided.... Individuality is only possible if it unfolds from wholeness.... It is

impossible to have true individuality except when grounded in the whole.... Anything which is not in the whole is not individuality but egocentrism.... The individual cannot be self-centered.... Anybody who is self-centered must be divided, because in order to become self-centered he must establish a division between himself and the whole...." (p. 35).

The new paradigm in nursing is based on health with the individual wholeness of the person in interaction with the environment. A paradigm of systems implies connectedness at every level. Persons, families and communities are the human systems of concern to cancer nursing practice. Viewing people as systems in interrelationships and in interconnection with each other, as well as connected with outside systems, allows the nurse to focus on humans in wholistic perspective.

In this model, individuals, families and communities are viewed as centers and fields of energy continually moving in dynamic interchange toward higher levels of expanding consciousness (Hanchett, 1979;

Hevie, 1979; 1981; Newman, 1979; 1983). Client systems are thus interconnected in the sense that each is continually interchanging energy with the environment and with other client systems.

The underlying pattern of the whole of each person, family or community is considered the implicate order, the implicit representation of the whole (Bohm, 1980). The explicit order, that which is visible as part of the underlying whole, can be seen in explicit, observable patterns such as vortices of energy, networks of transfer of matter and information, and boundaries of space, time and consciousness (Newman, 1983).

Pattern is interconnected with wholeness. Hanchett (1979) referred to pattern as a static description of the dynamic energized structures known as persons, families or communities. This concept of pattern provides a stop-gap picture, a freeze-frame view, a photographic representation of the whole of person, family or community.

As systems, person, family and community are organized as networks of relationships in interconnectedness. Networks are aggregates of connecting lines, links and channels. The circulatory

system of humans serves as a physiological example of a network as it provides for the distribution and redistribution of energies throughout the body. Likewise, a family network includes linkage of roles such as mother, wife and parent. This same network expressed in social terms for community includes neighbors, friends, teachers and employers. Each of these linkages is interconnected by and through relationships. Each provides the environment of surrounding people for the other. Each client system involves these interrelationships.

Interrelationships, viewed as movement or action, provide the pulse of client systems. The quality and quantity of energy interchanges manifested as patterned interrelationships provide the indexes for interpreting the health of persons, families or communities (Hanchett, 1979; Newman, 1979; 1983). It is the stop-gap picture, the freeze frame view of pattern that allows one to see the whole of person, family and community.

Movement

Movement, the manifestation of consciousness, is viewed in a complementary space-time relationship in which time and space perceptions are useful as

indications of health. Movement can be seen as waves of energy and energy transformation in the space and time of one's life.

Movement provides an index for pattern recognition. Patterns of energy interchanging with events or environments and energy interchange through relationships with others constitute health. For example, as a nurse relates to a person with cancer and the events associated with the process, no matter how instructive, constructive or destructive some forces might seem to be, the energy of the event augments one's own energy and gives one the power to move through the particular situation.

Transformation

Transformation begins with oneself. The issue is not to worry about how to change or help someone else change. The only need is to let go and allow the change to take place in oneself. It is important to accept oneself and let go of the "way to be" that is a prevalent admonition within health care circles. There is space-time-consciousness embedded in every person. The need is to attend to the universe of oneself. The task is to let go and allow the transformation to take place. This involves letting go of all emotions except

love.

Moss (1981) called for an unconditional love, an embracing of all experience, a valueless state of awareness. Such a state replaces varying intensities of mood and uncontrolled emotion and lifts the energy to a finer, more radiant quality. To be open is to be vulnerable, an important characteristic of humanness. To be vulnerable is often to suffer. Persons tend to avoid suffering, yet avoidance of suffering may deter movement to higher levels of consciousness. Suffering offers one the opportunity to transcend a particular situation or transform.

One is not diminished by vulnerability, suffering, disease or death. It is the protecting of oneself by binding off from these experiences that diminishes the person. The need is to let go, embrace the experience of cancer or other crises, and allow the expansion of consciousness to unfold.

Transformation then is conceptualized as expanding consciousness. Expanding consciousness occurs as a process of pattern recognition (insights) following a synthesis of contradictory events or disturbances in the flow of daily living. Pattern recognition is spontaneous, sudden insight in relation to a shift in organizational complexity affording greater freedom and

variety of responses to any given situation.

Hope

Hope emanates from within a person. It stems from trust in the worldly organization of things. Persons learn to trust themselves and to trust others to help when help is required. Hoping is not secret and solitary.

Hope is related to interconnectedness with others. It is part of the recognition of the interdependence individuals have for other people, on farmers to grow food, manufacturers and grocers to supply goods and services needed to maintain life.

Independence, in the sense of a human being not needing other people, is simply a myth. Hope is related to dreaming dreams. Hope is ever-changing, especially when dealing with the cancer process. Hope assists one in transformation. It is a positive force that enables a person in movement to treatment, to acceptance of change, to uncertain outcomes. It is a positive force. Hope enhances growth. Hope denotes the range of possibilities as being attainable. Hope is ever-present as one expands consciousness.

Disorder

It is important to address the phenomenon of disorder. What happens if a person facing the

diagnosis of cancer does not find meaningful care and nurturance during this process? What can happen to the person who seeks more than traditional care, but does not find it?

A person's behavioral repertoire can become restricted so that communication and sensory reception can be distorted. There is a perceived narrowing of options, diminished reliance upon intuition and a fixed or generalized response to diverse experience.

There is no sense of wholeness and a person can feel fragmented, disorganized and hopeless. Chaos may result. The need for information and support can be critical. The cancer diagnosis is viewed as a crisis and with crisis may come a realization that there is no hope, no power, and a sense of loss, being out of orbit with no guidance. Life's goals may be lost. There is an inability to visualize the future, other goals or new meaning.

The intervention of a nurse knowledgeable of the wholistic model of cancer care can change disorder into movement toward transformation and expanded awareness for the person with cancer. Disorder can be reversed then and recognized patterning can emerge and the whole becomes visible.

Application of the Model

To aid the reader in the application process of this wholistic model of cancer care, an elaboration of a case study presented earlier will be given. The role of the nurse also is discussed in detail.

Becky was a thirty-nine year old mother of three children who, eight months before, had had a lobectomy for lung cancer. She now presented to radiation therapy with subcutaneous tumors on the chest and buttocks and brain metastasis. Radiation was offered as palliative treatment.

Her children were twelve, seven and almost two years of age. Her husband had just lost his job. She was unable to work now. She was an occupational therapist at Veterans' Hospital and was applying for permanent disability.

The first encounter with the physician involved an explanation of her illness, what treatment would be offered, and the side effects of treatment. The nurse's meeting with Becky involved the interchange of information, eliciting personal data, and giving an explanation of the nurse's philosophy of care and the importance of Becky understanding that while the job title was registered nurse, the nurse felt a connectedness to her as a fellow human being and viewed

her as someone who was on the same level with the nurse. The idea that roles could be transcended was introduced and a sense of equality in the relationship was established.

During the first few meetings with Becky, the focus was on the cancer and she expressed much despair and was very fearful she would die and leave her children without a mother. While Becky's physical symptoms were assessed continually and care provided accordingly, her fears of death and leaving her children were explored as well. She began moving beyond the disease process and found herself opening her experiences and expanding her awareness.

She shared, in the beginning, the statement, "I can't do this. I feel like doctors are not relating to me as a person, but as a cancer that has a person." She moved far beyond her disease eventually to embracing the joy of each day with her family and facing her fears of not being with her children by preparing tapes for them to be given to each child on a chosen special occasion in the future. It was her way of participating in their future.

Becky clearly achieved a healthy state within the confines of cancer. Health was achieved by assisting her to recognize interaction patterns with her family.

The cancer became only a manifestation of that pattern, not the entity external to it, as it was in the beginning. Becky opened completely by gathering information on a continual basis throughout this process, and gaining power and control she moved forward toward awareness. **Cancer was not looked upon as a tragedy but as an opportunity.**

Before Becky died she said, "Once I started moving through this crisis, I began living a fuller life. I wouldn't want to go 'back to normal' (before cancer); I like moving on, the changes I'm experiencing. Oh, maybe I would stop the cancer now, but I wouldn't want to not have experienced all this."

Becky was a person who became a landmark. She was not afraid to grow and refused to be trapped by convention. She triggered in the health care team a new kind of interest and creativity, rather than the automatic pilot reaction to cancer. For the nurse, she provided the stimulation to look for more than is generally offered and the desire to search.

Regardless of the level of peoples' diseases, the action potential of their pattern of interaction focuses on their relationships with other people and their environments. **The task they are facing--the rules they must discover--is how to engage in**

meaningful reciprocal relationships. They want to talk about things that are important to them, to express a full range of emotions, and to be truly themselves. Often they do not, however, know how. This then becomes the goal of nursing.

The power of the medical model is such that, in a pinch, it predominates, and the nurse can feel diminished in terms of his or her nursing responsibility to the patient. **It also tends** to keep nurses within the confines of the old paradigm. If nursing is to fulfill its responsibility to the patient in implementing a paradigm of practice that recognizes disease as a manifestation of evolution toward higher consciousness, it will have to move forward to a system that integrates the valuable contributions of previous approaches and free the nurse to function as a full partner in health care.

Capra (1982) pointed out that nurses are perhaps the best prepared to offer health care within the new paradigm of health--health based on pattern recognition and facilitation rather than on diagnosis and treatment of disease. **Currently nurses are functioning in both** the old and new paradigms.

This new paradigm is based on health as the

undivided wholeness of the person in interaction with the environment. The wholistic model of cancer care views nursing practice as directed toward recognizing the pattern of this interaction and accepting it as a process of evolving consciousness.

The nurse utilizing this model does not establish a short-term relationship as does a nurse using the old model. Although the nurse is concerned with performing tasks related to the immediate medical regimen and self-care, the nurse also is sensing into the patient's field and facilitating the insight of pattern recognition.

Again the nurse and patient are not separate persons. They are persons experiencing the pattern of consciousness formed by their interaction. Their relationship is not limited to task performance.

Another role may be needed in order for nurses to function fully in this model. Nurses need to be free to relate to patients in an ongoing partnership that is not limited to a particular place or time. Patients should be able to choose their nurse in the same way they choose their physicians. Nursing usually operates for specific time-bound purposes.

An integrated team approach is needed in which all

participants in the health care team including the patient are viewed as equal partners. The current structure of health care is pyramid-shaped with the physician at the top and ancillary help underneath followed by the patient at the bottom of the pyramid. An integrated team approach is proposed here with nursing relating to other disciplines and the patient in the environment in a cooperative, mutual way. Everyone, including the patient, is viewed as an equal member of the health care team. Each brings to the interaction a meaningful dimension.

Table 2 compares the medical and wholistic models as they relate to a crisis. Table 3 schematically depicts the medical model and the wholistic model and distinguishes between the focus of care.

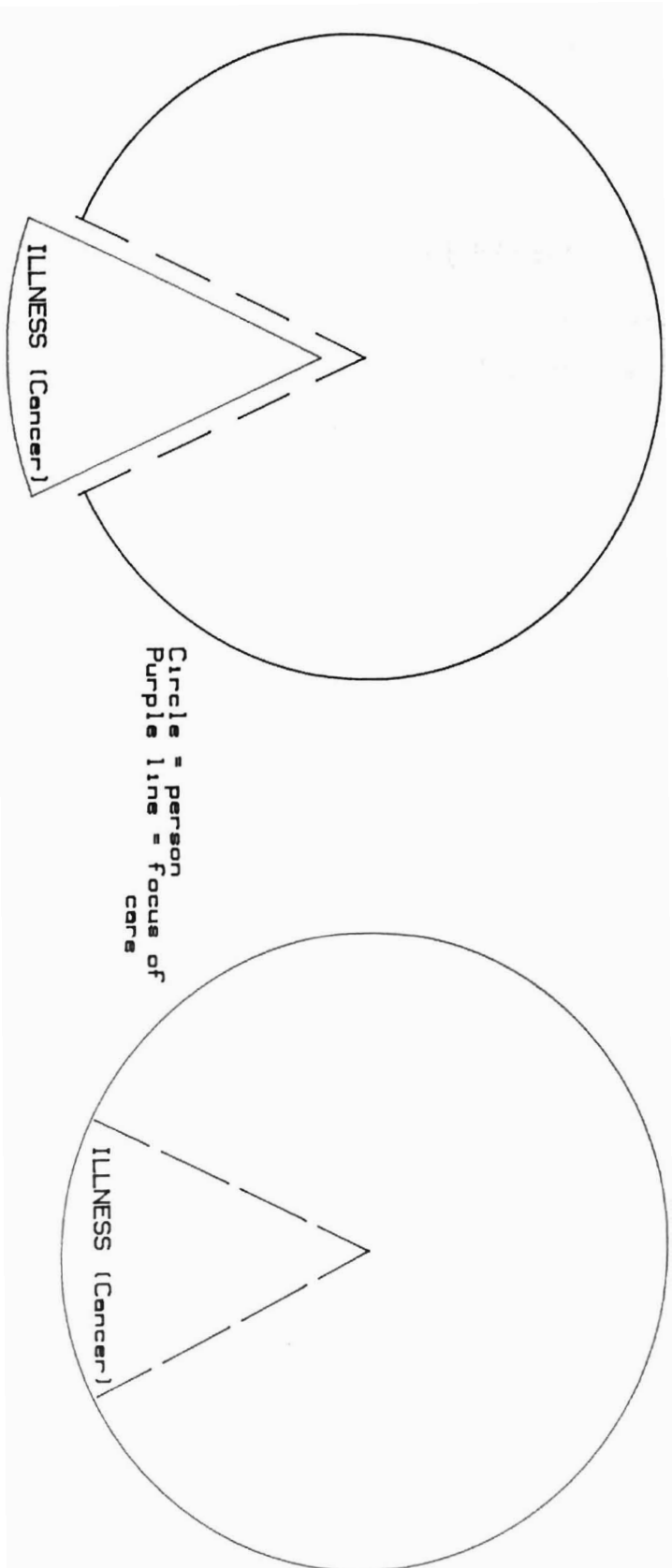
Table 2

A Comparison of the Medical and Wholistic Model of
Cancer Care

	Medical Model	Wholistic Model
Cancer	Viewed as something to be eradicated.	Viewed as a potential opportunity for growth and expanded awareness.
Goal of therapy	Restoration of level of functioning prior to cancer.	Promotion of growth of client through learning about self in relation to cancer.
Activity of therapist	Physician assesses and gives prescriptive response to a passive patient.	Nurse facilitates client's potential for self-growth.
Role of client and therapist	Patient complies with prescribed regimen. Patient values are not a significant part of therapeutic considerations. A dependent relationship is encouraged.	Client collaborates with nurse in assessing, developing plan and evaluating care. Clients' values and perceptions are a vital consideration.

Table 3
Medical Model vs. Wholistic Model

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The medical model strives to eradicate disease, or eliminate it completely from the person. The physician is dominant in directing care. The nurse implements the medical regime. The patient is a passive participant.

Terminology of Medical Model

Eradicate cancer
Prescribe treatment
Cure, control disease
Death is viewed as failure.

The wholistic model views cancer as part of the person. In this model the patient, physician, nurse, and family equally direct care.

Terminology of Wholistic Model

Person
Wholeness
Hope
Movement
Transformation
Environment
Nursing
Growth (Health)

Summary

Chapter Three introduced the wholistic model of cancer care for nursing practice and included the philosophy underlying the model. The four metaparadigm nursing concepts of health, person, environment and nursing were defined as well as the other key concepts of wholeness, movement, hope, transition, and disorder. A diagram of the model was included in this chapter, along with a comparison of the medical model and the new wholistic model. Application of the model and a detailed description of the nurse's role also were presented.

CHAPTER FOUR

SUMMARY, DISCUSSION AND RECOMMENDATIONS

Summary

A wholistic model of cancer care for nursing practice was presented in this research study. The theoretical foundation for the model was reviewed as well as the literature relevant to the development of the model.

Until now, when focusing care on the person with cancer, the emphasis in nursing has been to assist persons physically to treat them for cure, minimize symptoms of the disease or control the pain of cancer. Treatment efforts have focused on chemotherapy, radiation and surgical intervention, with some efforts directed at the psychosocial dimension of how to cope with the diagnosis and process of treatment. Little, until recently, has been done to explore the new wholistic paradigm of health that embraces a more humanistic approach to health care.

The wholistic model of cancer care for nursing practice presented embraces the new emerging nursing paradigm. Health has been redefined to include a broader definition that allows the person with cancer to enter the health care system as an equal partner and transform the cancer experience into a positive growth

process.

The wholistic model incorporates nursing's metaparadigm concepts of nursing, person, environment and health as well as the additional concepts of wholism, hope, movement, transformation and disorder. The model challenges the medical model that focuses on the diagnosis and treatment of symptoms and disease and purports to view cancer not as a disease that needs to be eradicated, but instead as a manifestation of the person. The focus is on the whole person, which includes the cancer, and views the patterns of interaction of the person and environment as the path to growth (health).

Discussion

There is a clarion call within the nursing profession for methodology consistent with the philosophical and theoretical perspectives of the discipline. The model developed in this study is one of the evolving pattern of the whole. The assumption made is that whatever manifests itself in a person's life is an explication of the underlying pattern. Cancer is not a separate entity; it is a manifestation of the person's pattern of consciousness. Eliminating the cancer does not necessarily enhance the evolving

pattern; in fact, actions toward this end may even impede the pattern. Pattern recognition is the key in the process of evolving to higher levels of consciousness.

In keeping with the notion that minimal health states can provide opportunities for growth and expanded awareness, one can view cancer as a situation in which perceptions of self and life purpose are open to question, when, in essence, the person is at a turning point. This wholistic nursing model, as opposed to the traditional medical model, emphasizes the potential growth enhancement that cancer offers rather than its pathogenic quality.

In contrast to the medical model that views the physician as the expert who utilizes crisis intervention to alleviate symptoms and restore the individual to physical and psychological equilibrium, this nursing model views the nurse as a facilitator who helps generate within the person who has cancer the potential for achieving self-growth and a more creative, healthful life pattern. The ultimate responsibility for health, however, remains with the client. Accordingly, nurse and client problem solve together to explore and monitor pattern recognition and

transformation. Change or movement toward transformation is aimed at achieving harmonious integration of the mind, body and spirit or the whole person.

The theory of health as expanding consciousness is conceived within a paradigm of health and science emphasizing pattern recognition of the evolving whole. It incorporates the self-organizing interplay of disorder and order, explicated as disease and absence of disease, in the process of moving to higher levels of consciousness.

Cancer is certainly not the only catalyst that could result in expanded awareness, but in terms of this model, it can and most often does bring about the motivation for change in a person, a new way to view the world and one's life in general. This process if assisted and enhanced can lead to health and expanded awareness.

Just having cancer is not sufficient alone to lead one to expanded awareness or health. The diagnosis of cancer usually brings one to the point of questioning and seeking assistance. It is at this time that the nurse can assist the person with cancer to recognize patterns of interactions with their environment and together they can explore options and relationships

within a space-time framework, and the whole becomes visible and attainable. It is in this wholeness that health is achieved.

Disorder results when the perceived need for help, hope and intervention does not get attention. If no attempt is made to intervene by someone with knowledge of wholistic health, persons may never get beyond the cancer and therefore their potential for growth and increased awareness is not realized. Clearly the actions of nurses can make a qualitative difference in people's lives that can in turn raise the standing of nursing as an enhancement to wholism and health, rather than just an adjunct to medicine.

Analysis of the Model

A major component of a model of nursing is its structure. In the selection of models, nurses are probably likely to choose a model of nursing based on the functional usefulness of the model. Is it workable? Is it understandable? Will this model add to the body of nursing knowledge?

To direct the development of this wholistic model for cancer nursing care and assess its adequacy, a framework for analysis of nursing model development proposed by Fawcett (1984) was employed. Chapter One

included a list of those questions and they will now be addressed in the analysis of the model.

The first question was: What is the historical evolution of the conceptual model? Motivation to develop the model came as the result of a deep concern for preserving humanity and rediscovering the human spirit. The model also expresses a commitment to move nursing away from the medical model that views illness as that which is to be eradicated. To envision illness as a health experience is contrary to the predominant health and illness paradigm. The paradigm of illness as the enemy has obscured viewing illness as a potentially positive health experience. This paradigm predominated nursing theory in the 50s and 60s. By the mid to late 1970s, with help from people like Rogers, Pelletier, Parse and Newman, the new paradigm of viewing health as expanding awareness emerged.

Crisis theory also supports this emerging paradigm. Historically crisis theory dealt with crisis intervention as a restorative process. Crisis theory envisioned a crisis as a health rather than illness process. In the 1980s, Hall and Ryff and Dunn, to name a few, started viewing crisis as a way to grow, to go beyond restoration. They saw crisis as an opportunity

to grow. This emerging view is one in which illness is viewed as an opportunity to learn about oneself (Pelletier, 1977) and to reflect on the meaningfulness of life (Moos, 1982). Clearly the concept of wholism increasingly appears in the nursing literature and has been established as especially congruent with nursing's essential nature.

The health within illness concept has been introduced to nursing through the recent research work of nursing theorist Margaret Newman since the early 1970s and has been refined and explored in more detail in the later 1980s and 1990s by other nursing colleagues as well as Newman. Kuhn (1970) believed that a new paradigm takes hold only when the ruling paradigm is no longer sufficient to solve the problems and meet the needs of a social system. Such a crisis exists in health care today. This crisis involves the economic demands of the health-care system, its responsiveness to the health needs of society and the credibility and performance of its practitioners. Because of this crisis, the context is ripe for a paradigm shift that will change remarkably the delivery of modern health care.

The second question was: What approach to the

development of nursing knowledge does the model exemplify? Conceptual nursing models not only differ in philosophical and cognitive orientations, but also in their development and structure. As indicated previously, models can be developed inductively from the nurse's empirical observations and intuitive insights or deductively from the realm of knowledge of other disciplines. The models also can be structured differently. Fawcett (1989, pp. 13-19) summarized that conceptual nursing models are structured according to the discipline or theoretical frameworks from which they were derived. Margaret Newman's (1976; 1986) nursing model of health as expanding consciousness and crisis theory provided the major theoretical bases for the development of this model. Newman (1979), expanding on a concept of health and illness suggested by Rogers (1970), proposed a view of health that includes a dialectical fusion of disease and non-disease, bringing about the synthesis of health. Newman proposed a humanistic existential model of nursing. The ontological view evolves from the idea that the person is an experiencing and perceiving being in the world. Person is the locus of human existence, a living, growing gestalt.

Crisis theory also supports the health within illness perspective. Learning about or coping with an illness is a potential crisis experience providing an opportunity for growth. The threat within the crisis situation poses a situation for a possible increase in a person's level of functioning.

Fawcett's third question asks: Upon what philosophical assumptions is the model based? The model of wholistic health presented here is based on the philosophical assumption that health can exist within the confines of illness. Consciousness or health is not an end in itself. It is a continuously expanding relatedness and responsibility to life as a whole. Nursing action in the care of the person with cancer is intentional and not unwitting, and has as its goal assisting the individual with cancer to a heightened energy of consciousness or expanded options. The cancer is viewed as part of the person, not necessarily something that has to be eradicated.

There are some tentative assumptions that may be drawn from this qualitative research study. They are:

- (1) Cancer may provide a catalyst for expanding consciousness and awareness.
- (2) Cancer itself is not a sufficient condition for experiencing health or expanded

consciousness.

- (3) Intervention and explorative enhancement are seen as coming from the nurse and client relationship as provided by their patterns of interaction and authenticity.
- (4) Disorder is the usual outcome without appropriate intervention or support.

How are nursing's four metaparadigm concepts-- person, health, environment and nursing--explicated in the model? What statements are made about the relationships among the four metaparadigm concepts? These are two other questions posed by Fawcett.

The wholistic model of cancer care proposes a new way to offer care for people with cancer that involves new conceptualizations of the four metaparadigm concept--health, person, environment and nursing. Each of the four concepts is explicitly defined and described. The additional concepts of wholeness, hope, movement, transformation and disorder inherent in the model also are identified and described.

In analyzing how the concepts of the wholistic model of cancer care are related, the concepts are identified, defined and described and relationships among the concepts are depicted. Most of the concepts are related categorically and sequentially. A time

dimension is incorporated in the relationships among the concepts, indicating a necessary, but not a sufficient relationship. This sequential relationship is evident in the development of expanding consciousness and awareness.

Fawcett's final question is: What areas of concern are identified by the conceptual model? The main area of focus and concern of this wholistic model is the process of attempting to understand and describe the person-environment interaction pattern. This model explicitly identifies that person and health are the central phenomena of nursing's concern. Although other models have considered the person in a wholistic manner, the view of person is distinctive in that the person is a unified whole and an experiencing, living, growing gestalt. Furthermore, although other models have considered health and environment in relation to person, the view of health in this model is distinct and visionary. The concern with focusing on the whole of the person in interaction with the environment is central to nursing practice, education and research. The importance of the role nursing assumes in this model was also described. The role of the nurse was explained as well.

This wholistic model of cancer care emphasizes the potential growth enhancement that cancer offers rather than its pathogenic quality. Thus the nurse assists the individual in moving beyond the baseline functioning manifested prior to cancer. Deviation from the norm is not seen necessarily as rooted in pathology and therefore, moving the client back within the bounds of "normative functioning" is not the expressed goal of wholistic nursing care. Within this nursing model, major emphasis is given to the growth-producing aspects of cancer.

Limitations of the Study

First and foremost, perhaps the biggest limitation of this study is that this model has not been scientifically tested at all except in the researcher's limited practice. This must be done in order to establish any true validity and reliability. Clarification of the concepts through concept analysis also is needed. In a pattern model, one is reminded that the pattern is subject to change and that the interpretation is rarely if ever completed.

Second, this model is based on a philosophy of care and no matter what skills are learned and performed, the salient dimension is the underlying beliefs and values that are brought to bear on how

skills are used and tasks accomplished. Self-awareness and caring suggest an internal set of principles underlying this philosophy. This may somehow alter the ways in which the model is utilized. It may be argued that the success of the model is dependent on whether nurses can espouse the philosophy presented.

Third, the success of this model may be contingent on its ability to become part of the education and socialization of new nurses. That will no doubt take some time, as wholism will increasingly become part of the nursing curriculum. The nursing literature is replete with calls for a wholistic, dynamic approach to knowledge development consistent with the basic philosophical assumptions and practice realities of the discipline.

Fourth, it may be said that this model requires the skills and education of a nurse at the graduate level. The development of a nurse practitioner role would be appropriate who had knowledge of this model.

The old paradigm embraces a hierarchical structure. The new paradigm specifies flexible relationships and necessitates the breaking up of old connections to make room for mutuality. The current upheavals in the organization of health services and

the views about science provide fertile ground for the development of new patterns of relationships.

Recommendations for Further Study

There are many opportunities for additional research of the model. The model supports the use of both quantitative and qualitative methods to validate knowledge. Virtually any setting and any person would be appropriate for research, with the provision that the person in his/her totality is considered. Phenomenological research inquiries that focus on the uniqueness of each person and attempt to describe and understand human experiences is encouraged. For example, further research regarding this model could be directed at explicating and studying the experience of people diagnosed with cancer. A research question may be: What is the experience of health for persons diagnosed with cancer? Specific hypotheses could include describing a person's lived experience with cancer and describing the experience of health as patterning of the person-environment interaction.

Recommendations for further research also could include further use of patterning analysis to determine its usefulness in developing knowledge relevant to the discipline of nursing. Research related to the

clarification of researcher involvement in the patterning process also is essential. Specifically, determinations need to be made about how to describe researcher involvement in the reporting of findings.

Health and wholeness need to be examined in light of the particular conditions that precipitate them, rather than pathology and problem development. Research methodologies and tools for measurement are needed to facilitate representative and reliable value analyses of individuals in the context of the meanings attributed to those values.

One application of the conclusion of this study is that the process of transformation to expanded consciousness has far-reaching constructive effects on quality of life, so that cancer is experienced as an opportunity for growth rather than deleterious. If this association of cancer and opportunity is documented in other research, clinical education programs in other disciplines might begin to address ways in which individuals and families experiencing other crises can be assisted to make transformation to expanded awareness in daily living.

Implications for Advanced Nursing Practice

This wholistic model of cancer care offers a new

vision as well as an adaptable framework with comprehensive implications for nursing practice. This model contributes to nursing theory development by offering a different philosophical orientation. This alternative philosophy seems to be an eclectic synthesis of idealism, progressivism and humanistic existentialism and a movement away from the scientific realism and logical empiricism of medicine. The ontological view of this model emphasizes the proposition that reality resides in the experiences of the person and is not absolute. Organicism and change that emphasize wholeness, context, open systems and continuous, creative change are stressed. It proposes a unitary nature of reality in which humans and nature are inseparable and connected.

The epistemic view of the model supports the belief that there is no ultimate or absolute truth. Knowledge is tentative, changing and constructed out of human experience. The development of knowledge is viewed as a never-ending process that arises from a synthesis of multiple ways of knowing.

The values of this model emphasize the primacy of the individual human being and an understanding of the meaning of human experience. Values evolve from human

experiences and are examined within the context of the whole. Values also are connected to social consequences.

The impact of this wholistic model on nursing theory development would be far-reaching into practice. The key characteristic of this theory change is that one fits the model to practice rather than the traditional approach of fitting the practice to a model. The philosophy presented offers a tangible vision for advanced nursing practice and becomes the foundation for change.

For educators who teach the concepts of this model, the framework allows for learning and growth on the part of the student and educator. All have the opportunity to achieve personal growth and self-awareness in the learning process. This model espouses the belief in the power of human consciousness, human freedom, human imagination, and human spirit as key components in teaching and learning. Learning is characterized as seeing the significance of life as a whole, discovering values and relating learning to personal reality. It must be viewed as a process in which the learner cultivates disciplined scholarship. This includes acquiring insights, seeing patterns,

finding meaning and significance, seeing harmony and wholeness, making compassionate and wise judgments, grasping the deeper structures of knowledge, enlarging the ability to think critically and creatively and finding new pathways to new knowledge. It also would place primacy in quality student-teacher relationships in which students are acknowledged as equal partners and active participants in learning. For the newly emerging paradigm to become part of the education and socialization of new members, content relating to wholism will need to increasingly become part of the nursing curriculum.

If administrators espouse the concepts presented in this model as applicable in their roles, major changes could occur in the hierarchy of administration. New personal insights could lead to a restructuring of nursing administration as well as medical administration. At this new level, defeat, failure and vulnerability are equally important as success, power and gratifying relationships. Winning is not important; experiencing the moment fully is.

This model advocates a discipline of nursing aimed at social and human possibility--a discipline that both seeks and doubts truth, develops its own personal

realities, advocates collaboration rather than competition; respects multiple ways of knowing; develops egalitarian rather than authoritarian relationships; appreciates humanistic values; re-evaluates its most basic assumptions about human life; focuses its energy to assist nursing to evolve into a service committed to enlightened compassion and develop nurses who can practice in tomorrow's world of true health care.

Seeing with eyes of wholeness means recognizing that nothing occurs in isolation, that problems need to be seen within the context of whole systems. Seeing in this way, one can perceive the intrinsic web of interconnectedness underlying one's experience and merge with it. Seeing in this way is healing.

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